Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL HERMANN HOSPITAL SYSTEM
3200 SOUTHWEST FWY STE 2200
HOUSTON TX 77027-7533

Respondent Name
VALLEY FORGE INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-08-0047-01

MFDR Date Received
August 30, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is the hospital's position that a unilateral, arbitrary reduction of its usual and customary charges by over 83% is inherently unfair and unacceptable from a commercial insurance company. . . . Requestor submits that a fair and reasonable rate for treatment of this injured employee is the usual and customary charges incurred."

Amount in Dispute: $30,272.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Provider has furnished no evidence which establishes that that Carrier's level of reimbursement does not meet the statutory standards for reimbursement; or that the overall reimbursement is insufficient in this case. . . . Accordingly, Provider has not met its burden of proof to show that the amount of reimbursement it seeks is 'fair and reasonable,' within the meaning of section 413.011 of the Act. Therefore, Provider is not entitled to additional reimbursement."

Response Submitted by: Stone Loughlin & Swanson, LLP, One Northpoint Centre, 6836 Austin Center Blvd., Suite 280, Austin, Texas 78731

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 31, 2006 to September 5, 2006	Inpatient Services	$30,727.88	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.

3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 45 – Charges exceed your contracted/legislated fee arrangement.
   - (900-021) – ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE NETWORK REFERENCED ABOVE.
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - (080) – REVIEW OF THIS BILL HAS RESULTED IN AN ADJUSTED REIMBURSEMENT OF $0.00
   - (080) – REVIEW OF THIS BILL HAS RESULTED IN AN ADJUSTED REIMBURSEMENT OF $30,558.52
   - (850-107) – ABR: INITIAL ALLOWANCE RECOMMENDED IN ACCORDANCE WITH THE SATE FEE SCHEDULE GUIDELINES. $169.00
   - (850-207) – ABR: RECOMMENDED ALLOWANCE IS IN ACCORDANCE WITH WORKERS' COMPENSATION FEE SCHEDULE/RULES. RECOMMENDED FINAL ALLOWANCE IS $30,558.52
   - (850-211) – ABR: THIS PROCEDURE IS INCLUDED IN THE GLOBAL VALUE OF ANOTHER BILLED. RECOMMENDED FINAL ALLOWANCE IS $0.00
   - (855-002) – RECOMMENDED ALLOWANCE IS IN ACCORDANCE WITH WORKERS COMPENSATION MEDICAL FEE SCHEDULE GUIDELINES. $6,058.62
   - (900-030) – ABR THIS BILL WAS REVIEWED THROUGH THE ADVANCED BILL REVIEW PROGRAM
   - (993) – THIS SERVICE IS NOT REIMBURSABLE.
   - 216 – Based on the findings of a review organization
   - (900-030) – CV: THIS CHARGE WAS REVIEWED THROUGH THE CLINICAL VALIDATION PROGRAM
   - W1 – Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information
   - (993) – SERVICE DENIED.

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 – "Charges exceed your contracted/legislated fee arrangement," and (900-021) – "ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE NETWORK REFERENCED ABOVE." Review of the submitted information found no documentation to support that the disputed services were subject to a contractual agreement between the parties to this dispute. Nevertheless, on October 27, 2011, the Division requested the respondent to provide a copy of the referenced contract(s) between the health care provider and the alleged network. The attorney for the respondent replied by letter dated November 14, 2011 that "Carrier has confirmed there was no contract for the dates of service in dispute." The Division concludes that the disputed services are not subject to a contracted fee arrangement or network fee reduction. The above denial/reduction reasons are not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to inpatient hospital services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 886.0. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
3. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
4. 28 Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor

position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iv).

6. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "Requestor submits that a fair and reasonable rate for treatment of this injured employee is the usual and customary charges incurred."
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
   - The requestor did not submit documentation to support that the charges billed are the facility's usual and customary charges for the services in dispute.
   - The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…" 22 *Texas Register* 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	December 14, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.